

# APPENDIX F Level of Care

Admit Discharge Transfer Other

Georgia Department of Community Health SOURCE LEVEL OF CARE AND PLACEMENT INSTRUMENT													
1. SOURCE TEAM NAME & ADDRESS  Telephone:  Provider ID#				2. Patient's Name (Last, First, Middle Initial):									
				3. Home Address:									
				4. Telephone Number;		5. County: :							
6. Medicaid Number			7. Social Security Number			8. Mother's Maiden Name:							
9. Sex	10. Age	11. Birthday	12. Race	13. Marital Status	14. Type of Recommendation 1. <input type="checkbox"/> Initial 2. <input type="checkbox"/> Reassessment		15. Referral Source						
This is to certify that the facility or attending physician is hereby authorized to provide the Georgia Department of Medical Assistance and the Department of Human Resources with necessary information including medical data.													
16. Signed _____ (Patient, Spouse, Parent or other Relative or Legal Representative) 17 Date _____													
Section B. Physician's Examination Report, Recommendation, and Nursing Care Needed					1. ICD 9 ICD /10		2. ICD9/10		3. ICD9/10				
18. Diagnosis on Admission to Community Care (Hospital Transfer Record May Be Attached) 1. Primary _____				19. Is Patient free of communicable disease? 1. <input type="checkbox"/> Yes									
Medications (including OTC)					Diagnostic and Treatment								
20. Name		Dosage	Route	Frequency	21 Type Frequency								
22. SOURCE SERVICES ORDERED: ECMS, _____													
23. Diet		24. Hours Out of Bed Per Day		25. Overall Condition		26 Restorative		27. Mental and Behavioral Status					
<input type="checkbox"/> Regular <input type="checkbox"/> Diabetic <input type="checkbox"/> Formula <input type="checkbox"/> Low Sodium <input type="checkbox"/> Tube Feeding <input type="checkbox"/> Other		<input type="checkbox"/> Intake <input type="checkbox"/> IV <input type="checkbox"/> Output <input type="checkbox"/> Bedfast <input type="checkbox"/> Catheter Care <input type="checkbox"/> Colostomy Care <input type="checkbox"/> Sterile Dressings <input type="checkbox"/> Suctioning		<input type="checkbox"/> Improving <input type="checkbox"/> Stable <input type="checkbox"/> Fluctuating <input type="checkbox"/> Deteriorating <input type="checkbox"/> Critical <input type="checkbox"/> Terminal		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> None		<input type="checkbox"/> Agitated <input type="checkbox"/> Noisy <input type="checkbox"/> Dependent <input type="checkbox"/> Confused <input type="checkbox"/> Nonresponsive <input type="checkbox"/> Independent <input type="checkbox"/> Cooperative <input type="checkbox"/> Vacillating <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed <input type="checkbox"/> Violent <input type="checkbox"/> Well Adjusted <input type="checkbox"/> Forgetful <input type="checkbox"/> Wanders <input type="checkbox"/> Disoriented <input type="checkbox"/> Alert <input type="checkbox"/> Withdrawn <input type="checkbox"/> Inappropriate Reaction					
28. Decubiti		29. Bowel		30. Bladder		31. Indicate Frequency Per Week of the following services:							
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Infected <input type="checkbox"/> On Admission Surgery Date _____		<input type="checkbox"/> Continent <input type="checkbox"/> Occas Incontinent <input type="checkbox"/> Incontinent <input type="checkbox"/> Colostomy		<input type="checkbox"/> Continent <input type="checkbox"/> Occas Incontinent <input type="checkbox"/> Incontinent <input type="checkbox"/> Catheter		Physical Therapy		Occupational Therapy	Restorative Therapy	Reality Orientation	Speech Therapy	Bowel Bladder Retrain	Activities Program
32. Record Appropriate Legend		IMPAIRMENT				Record Appropriate Legend		Activities of Daily Living					
1. Severe 2. Moderate 3. Mild 4. None		Sight	Hearing	Speech	Ltd Motion	Paralysis	1. Dependent	Wheel- Eats	Trans- Chair	Bathing	Ambulation	Dressing	
		<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	2. Needs Asst	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	
							3. Independent						
							4. nt						
33.. This patient's condition <input type="checkbox"/> could <input type="checkbox"/> could not be managed by provision of <input type="checkbox"/> SOURCE or <input type="checkbox"/> Home Health Services.:							37. Physician's Name (Print)						
34. I certify that this patient <input type="checkbox"/> requires <input type="checkbox"/> does not require the intermediate level of care provided by a nursing facility							38. Address:						
35. I certify that the attached plan of care addresses the client's needs for Community Care							39. Date Signed By Physician		40. Physician's Licensure No		41. Physician's Phone No		
36. Physician's Signature:													
ASSESSMENT TEAM USE ONLY													
42. Nursing Facility Level of Care? <input type="checkbox"/> Yes <input type="checkbox"/> No			43. L.O.S.		Certified Through Date		44. Signed by person certifying LOC:		Title	Date Signed	Phone		

## DCH FORMS NEEDED FOR HEARING REQUESTS

Rev.  
10/11

### SOURCE LEVEL OF CARE AND PLACEMENT INSTRUMENT-INSTRUCTIONS

4/11  
Rev.  
07/11

**Purpose:** The Level Of Care (LOC) page summarizes the client's physical, mental, social, and environmental status to help determine the client's appropriateness for SOURCE services. In addition, the LOC page represents the physician's order for all waived services provided by SOURCE.

**Who Completes Form:** Initial assessments are completed by a licensed nurse (RN or LPN), case manager. The LOC is always signed by the RN. The agency medical director or client's physician participates in all assessments and reassessments by completing designating sections of the LOC page and signing the form.

**When the Form is Completed:** The case manager completes the LOC page at initial assessments and reassessments, and transfers from one SOURCE site to another. Include the transfer date.

#### **Instructions:**

*Indicate whether this is an initial admit, discharge, or transfer and date agency would like change to occur. May write any other helpful information in the box or at top of page.*

### **SECTION I A. IDENTIFYING INFORMATION**

Client Information in Section I is completed from information obtained from referral source or individual (patient) being referred.

1. Enter complete name, address, telephone number, including area code, and Medicaid provider identification number of care coordination team.
  2. Enter client's last name, first name, and middle initial, in that order, exactly as it appears on the Medicaid, Medicare, or social security card.
  3. Enter home address of client, including street number, name of street, apartment number (if applicable), or rural route and box number, town, state and zip code.
  4. Enter client's area code and telephone number.
  5. Enter client's county of residence.
  6. Enter client's Medicaid number exactly as it appears on the Medicaid card.
  7. Enter client's nine-digit social security number.
  8. Enter client's mother's maiden name.
- 09, 10, 11. Enter client's sex ("M" or "F"), age, and date of birth (month/day/year).
12. Enter client's race as follows:
- |                            |                      |           |
|----------------------------|----------------------|-----------|
| A = Asian/Pacific Islander | H = Hispanic         | W = White |
| B = Black                  | NA = Native American |           |
13. Enter client's marital status as follows:
- |              |                |             |
|--------------|----------------|-------------|
| S = Single   | M = Married    | W = Widowed |
| D = Divorced | SP = Separated |             |
14. Check ( ) appropriate type of recommendation:
1. Initial: First referral to SOURCE or re-entry into SOURCE after termination
  2. Reassessment: Clients requiring annual recertification or reassessment because of change in status.

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15. Enter referral source by name and title (if applicable), or agency and type as follows:

MD = Doctor

S = Self

HHA = Home health agency

NF = Nursing facility

FM = Family

PCH = Personal Care Home

HOSP = Hospital

ADH = Adult Day Health

O = Other (Identify fully)

16, 17. Client signs and dates in spaces provided. If client is unable to sign, spouse, parent, other

relative, or legal/authorized representative may sign and note relationship to client after signature.

**NOTE:** This signature gives client's physician permission to release information to Case Manager regarding level of care determination.

### SECTION IB. PHYSICIAN'S EXAMINATION REPORT AND DOCUMENTATION

Section B is completed and signed by licensed medical person completing medical report.

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amended

18. The physician or nurse practitioner enters client's primary, secondary, and other (if applicable) diagnoses. (Nurse assessor may enter client diagnoses, but through review and signature on Appendix F, the physician or nurse practitioner confirms the diagnoses)

As of 1/1/2015 ICD 10 diagnosis along with ICD 9 are mandatory.

**NOTE:** When physician, nurse practitioner or Medical Director completes signature, the case management team indicates ICD codes. Enter ICD codes for "primary diagnosis", "secondary diagnosis" or "third diagnosis" in the appropriate box. Case management teams secure codes from ICD code book, local hospitals or client's physician.

19. The physician or nurse practitioner or Medical Director checks "yes" box to indicate if client is free of communicable diseases; if the member has a communicable disease or it is unknown, check "no".

20. List all medications, including over-the-counter (OTC) medications and state dosage, how the medications are dispensed, frequency, and reason for medication. Attach additional sheets if necessary and reference.

21. List all diagnostic and treatment procedures the client is receiving.

22. List all waived services ordered by case management team.

Please designate ADH level

23. Enter appropriate diet for client. If "other" is checked (✓), please specify type.

24. Enter number of hours out of bed per day if client is not bedfast. Check (✓) intake if client can take fluids orally. Check (✓) output if client's bladder function is normal without catheter. Check (✓) all appropriate boxes.

25. Check (✓) appropriate box to indicate client's overall condition.

26. Check (✓) appropriate box to indicate client's restorative potential.

27. Check (✓) all appropriate boxes to indicate client's mental and behavioral status. Document on additional sheet any behavior that indicates need for a psychological or psychiatric evaluation.

28. Check (✓) appropriate box to indicate if client has decubiti. If "Yes" is checked and surgery did occur, indicate date of surgery.

29. Check (✓) appropriate box.

30. Check (✓) appropriate box.

31. If applicable, enter number of treatment or therapy sessions per week that client receives or needs.

32. Enter appropriate numbers in boxes provided to indicate level of impairment or assistance needed.

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33. Case Management team with the Medical Director (admitting physician) indicates whether client's condition could or could not be managed by provision of Home and Community Services or Home Health Services by checking (✓) appropriate box.  
**NOTE: If physician indicates that client's condition cannot be managed by provision of Home and Community Services and/or Home Health Services, the member will not be admitted to SOURCE and should be referred to appropriate institutional services.**
34. Medical Director, admitting physician with Multidisciplinary Team certifies that client **requires** or **does not require** level of care provided by an intermediate care facility and signs on #36, confirming the GMCF review and LOC determination.
35. Admitting/attending physician certifies that CarePath, plan of care addresses patient's needs for living in the community. If client's needs cannot be met with home and community based services, **the member will not be admitted to SOURCE and will be referred to appropriate services.**
36. This space is provided for signature of admitting/attending physician indicating his certification that client needs can or cannot be met in a community setting. **Only a physician (MD or DO) or nurse practitioner may sign the LOC page.**

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**NOTE:** Physician or nurse practitioner signs within 60\* days of completion of form\*. Physician or nurse practitioner's signature must be original. Signature stamps are not acceptable. UR will recoup payments made to the provider if there is no physician's signature. "Faxed" copies of LOC page are acceptable.

- 37, 38, 39, 40, 41. Enter admitting/attending physician's name, address, date of signature, licensure number, and telephone number, including area code, in spaces provided.

**NOTE:** The date the physician signs the form is the service order for SOURCE services to begin. UR will recoup money from the provider if date is not recorded.

### 42, 43, 44. REGISTERED NURSE (RN) USE ONLY

42. The registered nurse checks (✓) the appropriate box regarding Nursing Facility Level of Care (LOC). When a level of care is denied, the nurse signs the form after the "No" item in this space. The RN does not use the customized "Approved" or "Denied" stamp.
43. LOS - Indicate time frame for certification, i.e., 3, 6, 12 months. LOS cannot exceed 12 months.
- #Certified Through Date - Enter the last day of the month in which the length of stay (LOS) expires.
44. Licensed person certifying level of care signs in this space, indicates title (R.N.), date of signature, and contact information.

**NOTE:** Date of signature must be within 60\*\* days of date care coordinator completed assessment as indicated in Number 17. Length of stay is calculated from date shown in Number 43#. The RN completes a recertification of a level of care prior to expiration of length of stay.

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# For SOURCE : LOS Certified Through Date = Expiration on PA

\* For SOURCE "Date of Signature" for the Physician and RN is extended to 90 days

*Distribution:* The original is filed in the case record. Include a copy with the provider assessment/ reassessment packet

### **DCH Issued Provisional Level of Care**

The Department of Community Health (DCH) issues this provisional Level of Care (LOC) on members who have a LOC that is expiring, has been interrupted, or have a LOC from a different agency (such as Nursing Home) . It is given at the sole discretion of DCH who must take into consideration the waiting list and fiscal year for unduplicated members. It is issued for a finite length of time. There are no appeal rights associated with this LOC. No letter of notification is associated with this LOC.

#### **Nursing Home/ Rehab/ Hospitalization --Provisional LOC:**

Issued for 90 days on Medicaid members leaving a Nursing Home, Rehabilitation Center, or prolonged hospital stay and who appear to still meet NH LOC per submitted DON R.

- DON R will be submitted.
- Don R indicates a need for assistance greater than 28, and
- DON R clearly demonstrates that informal support is unable to temporarily meet the member's needs. This may be a written narrative to the question, "what would happen if you did not have assistance for 60 days?"

✓ Remember to follow the Instructions for the DONR for persons institutionalized "If the applicant is living in a personal care home or nursing home, score the applicant according to the care he would receive if discharged. To determine the future need for care, include the following questions:

- a. Who will/would provide care in the home if the person was discharged?
- b. How much care will the person need?
- c. How much can the person do for him/herself?
- d. How often will assistance be provided/available?
- e. How long would this plan last? "

#### **Members transferring between agencies and changing locations—Provisional Level of Care:**

This LOC is issued for 30-90 days at the sole discretion of DCH. Information from a DONR must be submitted as outlined above in Nursing Home/ Rehab/ Hospitalization Provisional LOC.

#### **Reassessment with Questionable LOC --Provisional Level of Care:**

This LOC is issued for 3- 6 months. It is for Medicaid members who LOC is expiring/ expired, and the member has not been issued a renewal or has been denied a renewal by an outside agency. Member may appeal or agency may ask for a provisional LOC. This request may be given

- If there is evidence that member may have some condition that needs further exploration or documentation. (such as neurology assessment for dementia)
- DCH Legal requests that a provisional LOC be issued
- Complete admission/ renewal packet is made available to DCH

The medical director will sign the carepath for provisional services. DCH will issue and authorize the Provisional Level of Care form.